CBO expects that under the basic FEHB option, fewer dependents of active-duty personnel and retirees and their dependents under the age of 65 would enroll than currently rely on the military health care system. Under either of the enhanced options, enrollment would be substantially higher than current reliance. In all three options, enrollment among beneficiaries who are 65 years of age and eligible for Medicare would exceed current rates of reliance on the military health care system.

Not surprisingly, the total cost to the government would differ under the three FEHB options. The basic option would lead to a total cost to the government of $7.3 billion, or net annual savings of $1.7 billion after downsizing was completed. The other FEHB plans would increase net annual costs to the government by $1.4 billion and $3.1 billion, respectively.

CHAPTER I

INTRODUCTION

The U.S. military today maintains an extensive medical establishment, including hundreds of clinics, hospitals, and major medical centers. Employing thousands of active-duty and reserve physicians and thousands more of medical support personnel, it provides health care to about 6.4 million beneficiaries, either directly (in its own facilities) or by paying for medical care in the civilian sector.

The system of military facilities was developed, chiefly during World War II and the Cold War, to support military operations and military members and their families stationed in places where civilian medical care was not available. Over the years, however, the size and composition of the system have changed in response both to changes in wartime requirements--rising during the Cold War, falling since its end--and to new challenges in providing medical care to active-duty personnel, military family members, and retirees.

REQUIREMENTS FOR MEDICAL CARE

During the Cold War, wartime military medical requirements were based largely on the scenario of an all-out conventional war in Europe. The expected high casualty and injury rates generated demands for far more hospital beds and physicians' services than military budgets could afford. To meet that shortfall, the Department of Defense (DoD) planned for substantial backup hospital capacity through contingency agreements with the Department of Veterans Affairs and through civilian hospitals under agreements with the National Disaster Medical System. Nonetheless, the military services built large medical systems incorporating some 30,000 hospital beds in the United States and requiring the services of 13,000 active-duty physicians.

With the end of the Cold War, the wartime requirements for medical care declined dramatically.[1] Two factors prompted that decline: reductions in the number of active-duty and reserve personnel, and changes in the expected nature of future conflicts. Current defense planning is based on the need to be able to win two nearly

1. See testimony by William J. Lynn, Director, Program Analysis and Evaluation, Office of the Secretary of Defense, before the Subcommittee on Military Forces and Personnel, House Committee on Armed Services, April 19, 1994. The Section 733 Study of the Military Medical Care System was conducted by DoD in accord with section 733 of the National Defense Authorization Act for Fiscal Years 1992 and 1993.

simultaneous major regional conflicts rather than an all-out conventional war. Indeed, so sharply have wartime requirements plummeted that the military medical establishment in the United States now has more than twice the capacity needed to meet the wartime demand for medical care. Thus, basing the size of the system on current requirements could lead to substantial additional reductions in the number of facilities and personnel in the military health care system.

Meanwhile, DoD has also faced the issue of how to use the capabilities of its medical establishment in peacetime. Providing care for active-duty personnel required only a small portion of those capabilities, and deployments and other operational assignments still left the system with substantial excess capacity. The Congress has authorized DoD to use that capacity to provide peacetime care for other members of the military community--dependents of active-duty personnel and retirees, their families, and survivors. By offering peacetime care, DoD hopes to provide a valuable personnel benefit to aid in morale, recruiting, and retention, and to use military hospitals more fully while giving physicians and other medical personnel training in diagnosing and treating a broader range of patient conditions. DoD refers to providing such care as its "peacetime mission," although of course the health care needs of civilian beneficiaries must be met in wartime as well.[2]

APPRAISING WARTIME AND PEACETIME CARE IN A DOWNSIZED MILITARY MEDICAL SYSTEM

The issue of how much the requirements for wartime have actually declined has sparked considerable disagreement. But any significant reduction in the size of the military medical establishment would have a major impact on training and preparation for wartime, as well as on the way that DoD provides health care to the millions of people who rely on the military system.

A downsized system would contain much less excess hospital capacity than at present, and a larger share of physicians and other medical personnel would be assigned to deployable military units rather than to military hospitals and clinics in the United States. Thus, in the future, DoD may no longer be able to provide much peacetime health care in its own facilities. Instead, the department may have to consider other ways to fulfill its commitment to provide for the continuing health care of military beneficiaries.

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2. In Operation Desert Storm, for example, many active-duty medical personnel serving in military facilities were deployed to the Persian Gulf. Their places were taken in many cases by reserve personnel mobilized for the emergency. In a full-scale mobilization in which reserve personnel were needed to care for military casualties, civilian beneficiaries presumably would have to rely on care furnished by the civilian medical sector.

Even during the Cold War, the demand by beneficiaries for medical care exceeded the capacity of military medical facilities. Demands for peacetime care are projected to remain high even though wartime requirements--and the size of active-duty forces--have fallen dramatically. Thus, an increasing gap will arise between the care military beneficiaries need and the ability of the military system to provide it. The private sector, which has always provided some health care for military beneficiaries, will have to play a larger role in the future.

Despite the military drawdown, the demand by beneficiaries for care will remain high largely because of continued growth in the population of military retirees and their dependents and survivors. DoD projects that its total population of beneficiaries will decline between 1989 and 1999 by only about 9 percent, despite a reduction of 27 percent in the number of active-duty members and their dependents who are eligible for care. By 1999, more than 8 million people will remain eligible to receive their care through the military health system, and retirees and their families will make up a larger share--over 50 percent--than ever before.

In principle, DoD could separate its responsibility to provide beneficiaries with access to medical care from its direct provision of care in military facilities. Indeed, given that the department reimburses beneficiaries for care received from civilian providers, it already makes that separation. If it downsized the direct care system and focused a larger share of remaining medical resources on training for wartime, DoD might have to rely primarily on the private sector for peacetime care.

Within DoD, however, substantial opposition exists to the notion that the wartime mission can be separated from the direct provision of care to civilian beneficiaries. Military medical officials contend that reducing facilities and staffing could seriously jeopardize wartime readiness. In their view, military medical facilities and the care those facilities provide in peacetime are essential to train physicians and ensure medical readiness for wartime. In addition, they claim that they must support a large enough training base to attract, recruit, and retain medical personnel and sustain a core of military medical leaders.

IMPROVING WARTIME AND PEACETIME PERFORMANCE

The size of the military medical care system is only one factor in determining the department's ability to carry out its wartime mission and provide peacetime care. DoD must also provide adequate training to its military medical personnel and control its health care costs.

In response to pressures from the Congress and beneficiary groups, DoD has developed plans to reform its provision of peacetime health care while maintaining wartime readiness. The department's plan, known as Tricare--which is discussed in detail in Chapter 4--emphasizes improving the performance of the peacetime health care system. DoD has also evaluated its performance of the wartime mission, with specific reference to problems that surfaced during Operation Desert Storm, and set forth plans for improvement in its Medical Readiness Strategic Plan 2001. Under those plans, DoD would largely preserve the current size of its military medical establishment.

In this paper, the Congressional Budget Office reviews the requirements of wartime readiness and peacetime care and DoD's plans to improve readiness and provide such care. A discussion of alternative approaches in Chapter 5 first analyzes making readiness the focus of a downsized military medical system and then evaluates alternative ways to provide peacetime care to military beneficiaries.

In the face of diminishing wartime requirements, retaining the current military medical establishment can be justified only if two conditions are present: first, the provision of peacetime care must contribute to DoD's ability to perform its wartime mission; and second, the department should be able to provide peacetime health care cost-effectively. It is to those questions that this paper now turns.

CHAPTER II

THE WARTIME MISSION

Medical care of combat forces is an essential element of military capability. The military services have organized their wartime medical systems to provide care in several echelons, beginning with emergency care in combat zones and ranging up to rehabilitation in hospitals in the continental United States. Medical support systems are structured to provide personnel, facilities, and medical logistics at each echelon. The systems also require transportation capabilities to move casualties among echelons and to maintain the flow of medical personnel and supplies.

The details of those systems differ among the military services. For example, the Army focuses on care in forward combat zones, the Navy (and Marine Corps, which is supported by Navy medical personnel) aboard ships, and the Air Force historically on casualties received away from forward areas. Nevertheless, the requirements for resources are similar and underlie wartime planning. When experience (such as that in Operation Desert Storm) has shown that planning or resources are deficient, the Department of Defense and the services have tried to remedy the situation--for example, through the Medical Readiness Strategic Plan. For the most part, those efforts have focused on improving coordination among different echelons of care, evacuation of casualties, and the adequacy of medical equipment and logistics support.

According to the General Accounting Office's review of experience in Operation Desert Storm, other deficiencies appeared in the readiness of medical personnel to be deployed in the right numbers and with the right mix of medical skills. The question of skills raises the issue of whether the way DoD operates its medical system in peacetime adequately prepares medical personnel to perform their wartime missions. The Surgeon General for each military service and DoD have consistently contended that the current practice of using medical personnel to provide peacetime care to a largely civilian population continues to be the best way to train for wartime. The services also claim that such training serves other objectives, such as helping to attract and retain military physicians, and thereby contributes to wartime readiness.

Both because of the importance of having trained personnel and because that issue has largely been omitted from DoD's plans to improve medical readiness, the question of the adequacy of medical training in peacetime is the focus of this chapter. It is important to recognize, however, that many other concerns exist about wartime

readiness and DoD's ability to remedy such problems through its Medical Readiness Strategic Plan.

DoD's MEDICAL READINESS STRATEGIC PLAN 2001

Partly in response to the experiences of Operations Desert Shield and Desert Storm, in March 1995 DoD formally released its *Medical Readiness Strategic Plan 1995-2001*, the department's blueprint for handling its wartime mission. As it stands today, the plan presents a vision for change rather than a detailed statement of how the department intends to improve wartime readiness. DoD believes that it will be able to carry out that vision by evaluating and monitoring readiness as well as through collaborative and consultative efforts by civilian and military staff from the military services and the Director of Logistics (J4) from the staff of the Joint Chiefs.

Although DoD's plan addresses many of the important issues affecting medical readiness, such as the need for joint planning and training, it does not yet lay out specific requirements for resources or offer a schedule specifying how key objectives will be met. Without such detail, it is difficult to assess the department's prospects for improving wartime medical readiness. But the plan at least recognizes one central cause of wartime readiness problems--namely, that DoD historically has placed primary emphasis on providing peacetime care. Even the department has viewed that point as important enough to state that, "In retrospect, the focus during peacetime emphasized health care delivery . . . often at the expense of medical readiness."[1]

MILITARY MEDICAL FACILITIES AS TRAINING GROUNDS

The Department of Defense maintains that military medical facilities provide an excellent training ground for wartime. But findings by the Congressional Budget Office (CBO) indicate that the care furnished in military medical centers and hospitals in peacetime bears little relation to many of the diseases and injuries that medical personnel need to be trained to deal with in wartime.

The range of war-related injuries and illnesses that are likely to occur in a theater of operations falls into two categories of patient conditions:

- *Disease and nonbattle injuries* (DNBI), such as diarrhea, malaria, severe febrile illnesses and infections, or nonpsychotic mental disorders; and,

1. Department of Defense, *Medical Readiness Strategic Plan 1995-2001*, Preliminary Draft (October 1994), p. 37.

- *Combat-induced wounds or wounded-in-action* (WIA), such as open wounds and injuries from blunt and penetrating trauma, burns, or shock.

The mix of DNBI and WIA diagnoses that would need to be treated in an actual deployment would vary with the scale, duration, and location of the deployment, as well as with the nature of the specific scenario. By way of illustration, data on the U.S. marines in Vietnam reveal that about two-thirds of the inpatient diagnoses reported represented disease and nonbattle injuries, whereas the remaining diagnoses reported represented wounded-in-action admissions.

CBO analyzed the match between the diagnoses used to describe DNBI and WIA conditions, which might be expected to occur in theater, and the primary diagnoses among patients treated in military medical centers and hospitals. To conduct that comparison, using a method developed by the Naval Health Research Center, CBO reviewed more than 1 million records for patients in military medical facilities in 1993 (see Appendix A for a detailed description of that method).

Disease and Nonbattle Injuries

Some overlap exists between the cases that military medical personnel treat during peacetime and the disease and nonbattle injuries that they could expect to treat during wartime.

- About 75 percent of peacetime primary diagnoses at military medical facilities match primary diagnoses on the DNBI list. Among the most frequent primary diagnoses that matched, for example, were cases of inguinal hernia, delivery of a baby in a completely normal case, disturbances in tooth eruption, pneumonia, coronary atherosclerosis, and chest pain.

- The most common wartime diagnoses of DNBI conditions, however, do not appear frequently in the peacetime workload of military medical centers. The diagnoses included in the 25 most frequent disease and nonbattle injury categories reported for U.S. marines in Vietnam appear to match only about 20 percent of the 50 most common primary peacetime diagnoses.

In short, those findings show that peacetime medical care provides some training for wartime, but most of the care provided during peacetime is not relevant to even noncasualty wartime patients.

Wounded-in-Action

The value of peacetime practice is even more limited when applied to wounded-in-action conditions.

- Only about 5 percent of the primary diagnoses that military medical personnel treat during peacetime match the diagnosis of a battle-related injury.

- None of the 50 most frequent peacetime diagnoses at military medical centers match a wounded-in-action condition.

In other words, when one compares conditions of battle injury with the diagnoses treated at military hospitals and medical centers, peacetime care gives medical personnel almost no chance to practice their war-related skills and perform war surgery.

Those findings should not be surprising. After all, the diagnoses treated at military hospitals during peacetime reflect the health status and treatment of a wider mix of patients--young and old, male and female--living in far different circumstances than would be the case in wartime. For example, a military beneficiary typically does not face such dangers as fighting an enemy or operating dangerous equipment, which are routine for military personnel during a conflict.

Within the limits set by patient conditions, military medical facilities do in fact provide effective training. For example, medical centers serve as excellent training grounds for residents in graduate medical education (GME) programs, including some training relevant to wartime readiness. But to the extent that it crowds out other training, the treatment that military facilities provide during peacetime makes it difficult for many medical residents to gain adequate training for war-related conditions.

STRONG AREAS OF TRAINING

Despite the infrequency with which war-related injuries and illnesses occur among beneficiaries within the military system, some programs do exist to help medical personnel receive more intensive exposure to battle-related diagnoses.

Integration with the Trauma System

Two facilities--Brooke Army Medical Center and the Air Force's Wilford Hall Medical Center--are a part of the emergency trauma system in the city of San Antonio, Texas. As a result of that unique, if informal, relationship between the military and civilian communities, the Brooke and Wilford Hall emergency rooms routinely receive a substantial number of civilian patients with blunt and penetrating injuries caused by vehicle accidents, fires, falls, and gunshot and knife wounds.

Treating those injuries contributes strongly to wartime preparedness. Military medical personnel also learn other skills that are transferable to a wartime scenario. Examples include becoming familiar with treating patients in emergency conditions; working in a chaotic environment; setting priorities, organizing, and treating a large volume of patients efficiently; and evaluating critically injured patients quickly and providing rapid intervention.

Training Residents for Wartime

During their residency, many military physicians receive a form of training that is similar to the training at Brooke and Wilford Hall. Residents in the military's GME programs, for example, receive trauma training in both the military's medical and civilian facilities. Many civilian facilities serve as clinical training sites for physicians from all three services in their residency programs. The Air Force has at least six such affiliations with civilian facilities, the Navy has seven, and the Army has 13. Of those 26 civilian hospitals, many meet the criteria of the American College of Surgeons for a Level 1 trauma center (for example, they are capable of providing comprehensive emergency care 24 hours a day) and thereby offer training under pressure.

For the most part, however, all of those programs train military physicians only during their residencies. Once physicians complete residency, their exposure to war-related diagnoses is usually restricted to the caseload that they encounter in military hospitals. Of course, one can cite exceptions to that statement. To maintain trauma skills, for example, staff surgeons may take a refresher course run by Wilford Hall in trauma and critical care called TRACCS (Trauma Refresher and Critical Care Course for Surgeons).

Continued Medical Education

Military medical departments also rely on course work to teach both their staff physicians and their residents to care for injured patients. Advanced Trauma Life Support (ATLS) is one such course--less than one week in length--used to teach military medical providers how to care for casualties during the "golden hour," or early phase of treatment.

Although ATLS emphasizes emergency lifesaving skills for treating injured patients, one of the major criticisms of the course is that it emphasizes skills for dealing with civilian trauma over those needed to deal with combat or military trauma.[2] Several suggestions for improving the course emphasize the need to make ATLS more specific to military medical providers by training them in the skills needed to perform war surgery and by using simulated casualty populations based on actual combat casualties instead of civilian trauma victims.[3] But because the American College of Surgeons controls ATLS, DoD has little say in changing its design.

The services offer their medical officers the opportunity to take several other short courses throughout their careers to prepare them for their wartime roles. One such course offered by the Army, which is called the Combat Casualty Management Course (C-4A), teaches senior officers in the medical department how to manage a large number of casualties in a conflict.[4] Other courses, which would not normally be taught in a civilian medical school, are designed to provide medical officers with advanced training in infectious diseases and other potential threats, such as chemical warfare, that could occur in the field.

2. Col. Ronald F. Bellamy, "How Shall We Train for Combat Casualty Care?" *Military Medicine*, vol. 152 (December 1987).

3. For a discussion of the differences between war surgery and surgery in urban trauma centers, see Capt. Arthur M. Smith and Capt. Steven J. Hazen, "What Makes War Surgery Different?" *Military Medicine*, vol. 156 (January 1991).

4. For a description of the courses offered by the Army, see *Medical Corps Professional Development Guide* (Fort Sam Houston, Tex.: Army Medical Department, January 1994).

CHAPTER III

PEACETIME CARE

Medical care is a key part of the total compensation package that the military offers to active-duty personnel and their families; it is also a benefit that retirees and their family members enjoy. Satisfying such a diverse group of beneficiaries, many of whom believe they are entitled to "free" health care for life, has not been easy for the Department of Defense. Tighter budgets for defense, coupled more recently with the closing of many military medical facilities, will make peacetime care even more difficult for DoD to provide in the future.

SOME BACKGROUND ON THE MILITARY HEALTH CARE SYSTEM

About 8.3 million people worldwide are now eligible to receive their care through the military health care system. That number includes the 1.7 million men and women on active duty and about 6.6 million "nonactive" beneficiaries, including dependents of active-duty personnel, retirees and their dependents, and survivors of deceased military personnel. The number of active-duty personnel includes all medically eligible personnel in the full-time Guard and Reserve, Coast Guard, Public Health Service, and National Oceanic and Atmospheric Administration. The number of beneficiaries eligible to receive health care from the military is projected to decrease only slightly in the future (see Table 1).

Yet only about 6.4 million--or about 80 percent--of total eligible people actually rely on the military's system for their care. Some beneficiaries, particularly retirees, depend on sources outside the military (such as Medicare) for some or all of their health care. Others have private insurance, perhaps through their own employment or their spouse's employment, and use it to pay for health care in the civilian sector. Those so-called ghost eligibles, who do not use the military health care system at present, can reenter it at any time.

The Health Care Delivery System

The military health care system is not only one of the largest health care systems in the nation but also one of the most complex to manage because of the way it is structured. The military health care system is made up of two parts: the direct care system and the Civilian Health and Medical Program of the Uniformed Services

TABLE 1. NUMBER OF ELIGIBLE MILITARY HEALTH CARE BENEFICIARIES WORLDWIDE PROJECTED FOR 1999, BY BENEFICIARY CATEGORY AND LOCATION (In thousands)

Location and Age	Active-Duty Personnel[a]	Dependents of Active-Duty Personnel[b]	Retirees and Dependents[c]	All
United States				
Catchment Area[d]				
Under 65	1,201	1,701	1,688	4,590
65 or older	0	4	725	728
Total	1,201	1,705	2,412	5,318
Noncatchment Area[e]				
Under 65	192	372	1,184	1,748
65 or older	0	1	639	641
Total	192	373	1,824	2,389
All Beneficiaries				
Under 65	1,393	2,073	2,872	6,338
65 or older	0	5	1,364	1,369
Total	1,393	2,078	4,236	7,707
Overseas				
Catchment Area[d]				
Under 65	171	134	19	324
65 or older	0	0	2	2
Total	171	134	21	326
Noncatchment Area[e]				
Under 65	53	48	23	123
65 or older	0	0	8	8
Total	53	48	31	131
All Beneficiaries				
Under 65	223	182	42	447
65 or older	0	0	11	11
Total	223	182	52	457
Total				
Catchment Area[d]				
Under 65	1,371	1,835	1,707	4,913
65 or older	0	4	727	731
Total	1,371	1,839	2,434	5,644
Noncatchment Area[e]				
Under 65	244	420	1,207	1,871
65 or older	0	1	648	649
Total	244	421	1,854	2,520
All Beneficiaries				
Under 65	1,616	2,255	2,914	6,784
65 or older	0	5	1,374	1,380
Total	1,616	2,260	4,288	8,164

SOURCE: Congressional Budget Office based on data provided by the Department of Defense.

a. Includes medically eligible personnel in the full-time Guard and Reserve, Coast Guard, Public Health Service, and National Oceanic and Atmospheric Administration.

b. Includes all dependents of medically eligible personnel.

c. Includes survivors.

d. Term used to define an area roughly 40 miles around a military hospital.

e. Term used to define an area outside of a 40-mile radius around a military hospital.

(CHAMPUS), an insurance program that covers most of the cost of care from civilian providers.

In 1995, the Department of Defense will spend $15.2 billion to operate the military health care system, or approximately 6 percent of the total budget for defense. DoD will spend $11.7 billion of that $15.2 billion on the direct care system and other activities such as education and training programs. CHAMPUS will consume the rest. As is the case with most other parts of the defense budget, the entire health care budget is considered a discretionary rather than an entitlement portion of the federal budget.

Beneficiaries who use the military health care system receive most of their care through the direct care portion of the system. CHAMPUS reimburses most of the cost of the remaining care, which beneficiaries receive from civilian providers (see Table 2 for a description of the health benefits offered by the military).

Direct Care System

Hospitals and clinics operated by the Army, Navy, and Air Force make up the direct care system, the larger of the two parts of the military system. It includes more than 120 hospitals plus more than 500 clinics in the United States and overseas. According to DoD projections for 1995, more than 55,000 civilian personnel and about 135,000 active-duty military personnel work for or support the system.

Although the medical services that the direct care system provides are virtually free to the beneficiary, the capacity of facilities, other resources, and a priority system limit access to the system. Statutes regulate the order of priority in which different groups of beneficiaries may receive care at military medical facilities. For example, active-duty personnel are entitled to receive first priority for care.

Other eligible beneficiaries who are not on active duty may use military medical facilities but only when space and resources are available. Family members of active-duty personnel have second priority, and retirees and their dependents and survivors come last. As a practical matter, access to the direct care system for beneficiaries also depends on whether they live close enough to a military medical facility to depend on it as their primary source of care. About 70 percent of the total eligible population--but only about 55 percent of those who are 65 years of age or older--lives within 40 miles of a military hospital. A smaller, but growing, proportion of the total population lives farther than 40 miles away.

CHAMPUS

When direct care is not available, or when military facilities are located too far away, some beneficiaries can use CHAMPUS. That program is only intended to supplement the care that beneficiaries receive at the military treatment facilities. In fact, beneficiaries within hospital service areas must receive authorization to use CHAMPUS from local hospital commanders in the form of a statement of nonavailability, which states that the required care cannot be provided in military facilities. Unlike other fee-for-service insurance plans, CHAMPUS does not require eligible beneficiaries to pay a premium.

Out-of-pocket costs are higher to beneficiaries for most medical services under CHAMPUS than through the direct care system. People eligible for CHAMPUS include dependents of active-duty personnel along with retirees under

TABLE 2. HEALTH CARE BENEFITS UNDER THE CURRENT MILITARY HEALTH CARE SYSTEM

Beneficiary Category	Inpatient and Outpatient	
	Direct Care System	Civilian Providers
Active-Duty Service Members (ADs)	Entitled to care. First-priority access at the military treatment facilities (MTFs).	Not eligible (may receive some specialty and emergency care).
Active-Duty Dependents (ADDs)	Eligible for resource-available care at the MTFs behind ADs.	Entitled to care, but may need a nonavailability statement.
Retirees, Their Families, and Survivors Under Age 65	Eligible for resource-available care at the MTFs behind ADs and ADDs.	Entitled to care, but may need a nonavailability statement.
Retirees, Their Families, and Survivors Age 65 and Over	Eligible for resource-available care at the MTFs behind ADs and ADDs.	Not eligible.

SOURCE: Congressional Budget Office based on data from the Department of Defense.

NOTE: A nonavailability statement is a certification from a military hospital that says it cannot provide the care a beneficiary needs. Civilian providers are reimbursed under a fee-for-service program called the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). All beneficiaries must first seek their care through the military treatment facilities. If care is not available or beneficiaries live too far away from an MTF, certain beneficiaries may use civilian providers under CHAMPUS in certain circumstances.

age 65 and their dependents and survivors. Active-duty personnel are not eligible for care under CHAMPUS. When beneficiaries reach age 65, Medicare replaces CHAMPUS coverage.

Managing the Military Health Care System

Managing the military health care system in an efficient manner is difficult. Not one but four organizations and officials participate in its management: the Assistant Secretary of Defense for Health Affairs and the Surgeons General of the Army, Navy, and Air Force. The Assistant Secretary for Health Affairs is the principal advisor to the Secretary of Defense for all health policies, programs, and activities and is responsible for setting policy and overseeing the wartime and peacetime capability of the military health care system. Each service is responsible for managing its own hospitals, clinics, and military medical personnel.

PROBLEMS WITH THE PEACETIME HEALTH CARE SYSTEM

Over the last 10 years or so, providing peacetime health care has been a constant concern for DoD. The department has tested one reform after another under the close scrutiny of beneficiaries, the services themselves, and in many cases the Congress. Most of DoD's reforms have focused on ways to address three specific, yet very different, problems of the military health care system: its increasing cost to DoD, its inefficiencies, and dissatisfaction among beneficiaries. Examples of the demonstration programs that have been tested by the Department of Defense include the Catchment Area Management demonstration and the CHAMPUS Reform Initiative.

DoD's Costs

Over the years, the resources devoted to medical care have steadily increased. From 1979 to 1995, DoD's total medical budget grew from $3.8 billion to $15.3 billion in current (or nominal) dollars. Increases in the cost of CHAMPUS and inflation in medical prices account for much of that growth. But DoD's medical budget has also risen substantially after adjusting for inflation. As measured in 1995 constant dollars, from 1979 to 1995 the total medical budget grew by about 65 percent--from $9.3 billion to $15.3 billion--during a period when the overall defense budget first rose but then fell almost to its initial level (see Table 3). Most of the increase in the total medical budget took place between 1980 and 1990, and the same trend can be

TABLE 3. TRENDS IN DoD's TOTAL MEDICAL BUDGET
(By fiscal year, in billions of dollars of total obligation authority)

Budget Category	1979	1989	1995
	In Nominal Dollars[a]		
Operation and Maintenance	2.0	6.6	9.6
Procurement	0.1	0.3	0.3
Military Personnel	1.5	4.5	5.1
Construction	0.2	0.4	0.3
Total	3.8	11.8	15.3
	In Constant Dollars[b]		
Operation and Maintenance	5.2	9.2	9.6
Procurement	0.1	0.3	0.3
Military Personnel	3.5	5.3	5.1
Construction	0.4	0.5	0.3
Total	9.3	15.2	15.3

SOURCE: Congressional Budget Office based on data provided by the Department of Defense.

NOTE: DoD = Department of Defense.

a. Includes inflation.

b. Measured in 1995 dollars. Calculations of constant dollars were made by constructing a composite index consisting of the medical portion of the consumer price index, the producer price index, and specific deflators published by DoD.

seen in DoD's per capita medical spending. Measured in 1995 dollars, per capita health care costs for the military grew by about 63 percent during that period.[1]

Paying for those increased costs has forced DoD to make trade-offs among programs. In 1995, DoD will spend at least 6 percent of its total budget on the military health care system. By contrast, in 1979 (at a time when the budget for defense roughly equaled today's level), spending on military medical care accounted for less than 4 percent of DoD's total budget. If future spending on medical care either remains level or increases--and if budgets for the department continue to

1. Because of differences between the military and civilian populations, as well as between the benefits offered by the military and the civilian sector, CBO does not compare per capita health care costs for the civilian sector with those for the military.